TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
VALLEY VIEW SURGICARE PTNRS

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-15-2045-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MARCH 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was originally submitted with a billing error. The statement requesting payment at 235% of CMS was omitted. The implant charge that was accidentally submitted on the claim has been removed. We are disputing the underpayment of the surgical procedures."

Amount in Dispute: $2,884.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due."

Response Submitted by: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2014	Ambulatory Surgical Care for CPT Code 25400-LT	$2,884.27	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P1-No code description given.
   - P12-Workers compensation jurisdiction fee schedule adjustment..
   - W3-Request for reconsideration.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- BL-This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.

Issues

Is the requestor entitled to additional reimbursement for code 25400?

Findings

28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

CPT code 25400 is defined as "Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)."

28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

According to Addendum AA, CPT code 25400 is a non-device intensive procedure.

The City Wage Index for Dallas, TX is 0.9831.

The Medicare fully implemented ASC reimbursement for code 25400 CY 2014 is $2,089.06.

To determine the geographically adjusted Medicare ASC reimbursement for code 25400:

The Medicare fully implemented ASC reimbursement rate of $2,089.06 is divided by 2 = $1,044.53.

This number multiplied by the City Wage Index is $1,044.53 X 0.9831 = $1,026.87.

Add these two together $1,044.53 + $1,026.87 = $2,071.40.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

$2,071.40 X 235% = $4,867.79. The respondent paid $4,877.87. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		06/11/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.